Notice of Controversion of Right to Compensation

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U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Longshore and Harbor Workers' Compensation

This report is mandatory and is authorized by law and regulation (33 USC 914(d), (e); 20 CFR 702.251). Failure to report when controverting right to compensation can result in liability for 10 per cent additional compensation.

OMB No. 1215-0023

Instructions: This form may be used by the employer/carrier to controvert the right to compensation. 33 USC 914(a) requires the employer to pay compensation promptly and without an award unless the right to such compensation is controverted by the filing of this form. Failure either to pay each installment of compensation, or controvert the right to such compensation, within fourteen days after it becomes due may result in liability for additional compensation equal to ten percent of each installment not paid when due (33 USC 914(d), (e). If the right to compensation is controverted, this form should be submitted in triplicate to the District Director, and the reasons for such controversion should be fully stated in item 12. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

1. OWCP File No.

2. Employer File No.

3. Carrier File No.

4. Claimant's Name and Address
First Name * M.I. Last Name *
name:
* line 1: city: country:
line 2: state: zip:

5. Claim File or Injury Reported Under (check one) *
- LHWCA
- OCS
- DCWCA
- NFIA
- DBA

6. Employee's Name and Address If different from Claimant's
country:
city:
st: zip:

7. Employer's Name and Address *
country:
city:
st: zip:

8. Carrier's Name and Address *
ctry:
city:
st: zip:

9. Nature of Injury or Occupational Disease

10. Date of Injury (Month, Day, Year) *

11. Date of Employer's First Knowledge of Injury (Month, Day, Year) *

12. Right to compensation is controverted for the following reason(s) *

13. Authorized Signature *
Signature

14. Title and name of person signing *

15. Date of this Notice * (Month, Day, Year)
11/04/2003

16. **(OWCP USE)** A copy of the form was mailed to the claimant and/or representative

on _____ . Initials _____ .

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Division of Longshore and Harbor Worker's Compensation, U.S. Department of Labor, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND COMPLETED FORMS TO THIS OFFICE.